

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1693

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01665

Reg. Dist. No. 190

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkridge Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkridge Rural</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hillside Rd. Box 222</u>		STREET ADDRESS (If rural, give location) <u>Box 222 Hillside Rd</u> 1	
3. NAME OF DECEASED (Type or Print) (First) <u>Mary Edna</u> (Middle) <u>Realear</u> (Last) <u>Miller</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>4</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Jan 4 1893</u>
9. AGE last birthday <u>72</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Howard Co. Md</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lucianus Cole</u>		14. MOTHER'S MAIDEN NAME <u>Mary Edna Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs Ruth Stueck Box 294</u>		18. ADDRESS <u>Elkridge 27 Md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of Rectum Dec 194

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) General Carcinomatosis 6 mo(c) Secondary Anemia & Hemoglobin

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct, 1954, to Feb 4, 1955, that I last saw the deceased alive on Feb 4, 1955, and that death occurred at 11:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Feb 7 1955</u>	<u>Meadowdale Mem Park</u>	<u>Harvey</u>	<u>Maryland</u>
DATE REC'D BY LOCAL REG. <u>Feb 7 55</u>	REGISTRAR'S SIGNATURE <u>E. Bird Williams</u>	24. FUNERAL DIRECTOR <u>Dr. W. H. Davidson, Laurel, Md</u>		

B.

BUREAU V. S.

FEB 10 1975

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01666

Reg. Dist. No. 191

Item 2, File 4177 2-25-55 et

1. PLACE OF DEATH- COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Ellicott City		LENGTH OF STAY (in this place) 7 mos		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore Middletown 10 x 2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highland Manor				STREET ADDRESS Monte Belli Hosp. R.F.D.	
3. NAME OF (Type or Print) EDNA J. BUCHANAN		(First) (Middle) (Last)		4. DATE OF DEATH February 12, 1954	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Jan 7 1875	9. AGE last birthday 80 yrs.	If under 1 year If under 24 hrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Broad Run Md.	
13. FATHER'S NAME John H. Grove		14. MOTHER'S MAIDEN NAME Laura V. Rudy		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. None		17. INFORMANT Miss Effie C. Grove	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause 421.4				(a) Chronic valvular heart disease			
Antecedent cause(s)				(b) Myocardial infarction		6 months	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last				(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 1, 1954 , to Feb 12, 1955 , that I last saw the deceased alive on Feb 14, 1955 , and that death occurred at 10:14 m., from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS [Signature] DATE SIGNED 2/15/55			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 2/15/55		NAME OF CEMETERY OR CREMATORY Rose Hill cemetery		LOCATION (City, town, or county) (State) Hagerstown Md.	
DATE REC'D BY LOCAL Feb 15, 1955		REGISTRAR'S SIGNATURE John B. Loughran		24. FUNERAL DIRECTOR Andrew K. Coffman		ADDRESS Hagerstown Md.	

Feb. 17, 1955 of Rev. B. E. L.

BUREAU V. S.

FEB 23 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1685

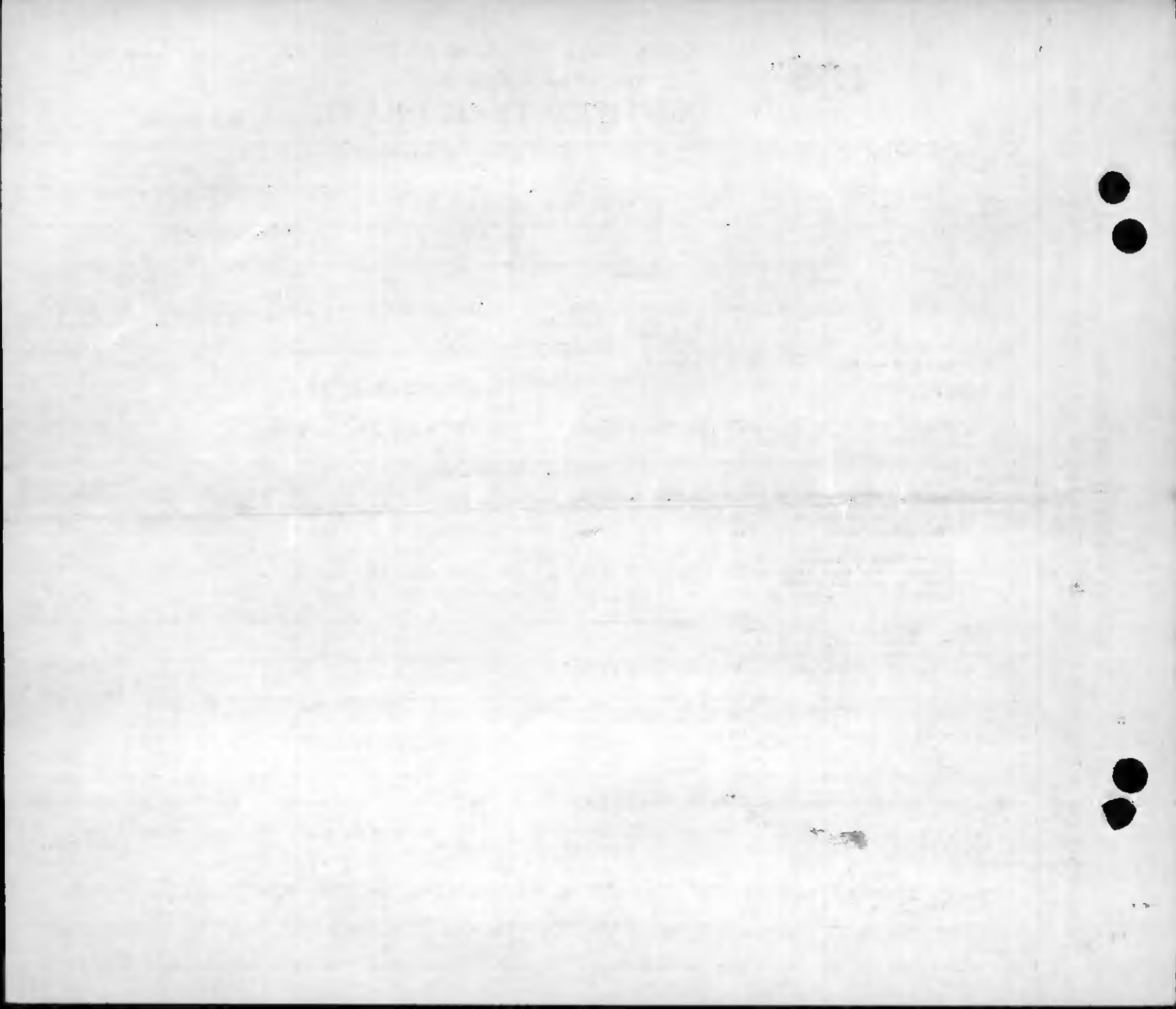
01667

1. PLACE OF DEATH- COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u> TOWN <u>Elkridge</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rear of 2019 Towson Ave</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge (Rural)</u> TOWN <u>Elkridge</u> STREET ADDRESS <u>Rear of 2019 Towson Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Fannie Catherine</u> (First) <u>Cooper</u> (Last)		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>21</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 27, 1903</u>
9. AGE last birthday <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Harrisburg Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stanley Stoneifer</u>		14. MOTHER'S MAIDEN NAME <u>Heldridal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr Joseph Cooper</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
260X Immediate cause (a) <u>Chor. Myocarditis & decompensation</u>		<u>2 mo</u>	
Antecedent cause(s) (b) <u>Diabetes mellitus</u>		<u>10 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>General Arteriosclerosis</u>		<u>10 yrs</u>	
19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1955</u> , to <u>Feb 21, 1955</u> , that I last saw the deceased alive on <u>Feb 21, 1955</u> , and that death occurred at <u>10:35</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Dr. B. Brumblough</u>		ADDRESS <u>3609 Main St Elkridge Md</u>	
DATE SIGNED <u>2/21/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb 24, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Baust. Cemetery</u>		LOCATION (City, town, or county) <u>Union Bridge, Md.</u>	
DATE REC'D BY LOCAL REG. <u>2-23-55</u>		24. FUNERAL DIRECTOR <u>Benjamin W. Jenkins & Sons, Inc.</u>	
ADDRESS <u>4985 York Road</u>		<u>Baltimore 12, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1686

CERTIFICATE OF DEATH

Reg. Dist. No.

01668

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Ellicott City</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highland Manor</u>				STREET ADDRESS (If rural give location) <u>115 W. Mulberry St</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Lauran Dorman</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>Feb. 26, 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Dec. 14, 1870</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Rt. Book Salesman</u>				10. B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>John Dorman</u>				14. MOTHER'S MAIDEN NAME: <u>Laura Langesdale</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <u>no</u> or unk.) (If Yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Lorena Gagger, 1624 Mt. Royal Ave.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>450.0</u>							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>arteriosclerosis, generalized; Senility; Urinary tract</u>							
(B) <u>infection.</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-19, 1955</u> to <u>2-26, 1955</u> that I last saw the deceased alive on <u>2-19, 1955</u> , and that death occurred at <u>6:45 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert B. Taylor</u>				M. D. <u>Ellicott City, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/1/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery, Baltimore, Md.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>2/28/55</u>		REGISTRAR'S SIGNATURE <u>Chas. Hedrick</u>		24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	

1990-1991

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

1687

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	STATE <u>Anne Arundel</u> COUNTY	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>
<input checked="" type="checkbox"/> TOWN <u>Ellicott City</u>	LENGTH OF STAY (in this place)	STREET ADDRESS (If rural give location)	<u>02-10-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highland Manor</u>		<u>Annapolis</u>	
3. NAME OF DECEASED: (Type or Print)	(First) <u>EDITH</u> (Middle) <u>N.</u> (Last) <u>JOHNSON</u>	4. DATE OF DEATH:	(Month) <u>Feb.</u> (Day) <u>17</u> (Year) <u>1955</u>
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u>	8. DATE OF BIRTH: <u>Unk. 1879</u>
9. AGE last birthday: <u>76</u> yrs.	10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Edward Rogers</u>	14. MOTHER'S MAIDEN NAME: <u>Unk</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>(If Yes, give war or dates of service)</u>	16. SOCIAL SECURITY No.: <u></u>
17. INFORMANT & ADDRESS: <u>Mrs. Marrie Kleeman</u>		<u>Wlen *urnie, Md.</u>	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	Interval Between Onset And Death
<u>443X</u>	<u>2 days</u>
Immediate cause	
(a) <u>Acute leukemia</u>	
DUE TO	
(b) <u>Recurrent HCV disease</u>	<u>10 days</u>
Antecedent cause(s)	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	
(c)	

11. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY?	Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>Feb. 1, 1955</u> , to <u>Feb. 17, 1955</u> , that I last saw the deceased alive on <u>Feb. 16, 1955</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.	
SIGNATURE <u>[Signature]</u>	DATE SIGNED <u>Feb. 17, 1955</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	NAME OF CEMETERY OR CREMATORY
<u>BURIAL</u>	<u>Cedar Hill</u>
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 19, 1955</u>	REGISTRAR'S SIGNATURE <u>John B. Loughman</u>
	FUNERAL DIRECTOR <u>JOHN M. TAYLOR & SONS</u>
	LOCATION (City, town, or county) <u>Annapolis, Md.</u>
	ADDRESS <u>Annapolis, Md.</u>
<u>Feb. 24, 1955</u>	<u>Per. B. E. L.</u>

MARGIN RESERVED FOR FINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 1 1953

BUREAU V. S.

1688

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Howard</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Prince George</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>near Fulton</i>	LENGTH OF STAY (in this place) <i>3 months</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>College Park</i>	<i>14</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Simons Rest Home</i>		STREET ADDRESS (If rural give location) <i>7504 Princeton Avenue</i>	<i>✓</i>
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>Ella</i>	(Middle) <i>H.</i>	(Last) <i>Krueger</i>	DATE OF DEATH: <i>February 27 1955</i>
5. SEX. <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>March 27, 1872</i>
9. AGE last birthday <i>82 yrs.</i>		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>housewife own home</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>own home</i>	
11. BIRTHPLACE (State or foreign country): <i>Howard Co Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>Philip T. Beall</i>		14. MOTHER'S MAIDEN NAME: <i>Ann Amelia Penn</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i>		16. SOCIAL SECURITY NO. <i>---</i>	
17. INFORMANT & ADDRESS: <i>4710 Harwich Rd Mrs Robert Grimes College Park, Md</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Chronic myocardial failure</i>			<i>1 week</i>
ANTECEDENT CAUSE (B) <i>arteriosclerotic heart disease</i>			<i>2 years</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Dec 28 1954</i> , to <i>Feb. 27, 1955</i> , that I last saw the deceased alive on <i>Feb. 27, 1955</i> , and that death occurred at <i>11:50 A</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Charles S. Whitaker</i>		DATE SIGNED <i>2/28/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		NAME OF CEMETERY OR CREMATION LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <i>3-1-55</i>		REGISTRAR'S SIGNATURE <i>Marie A. Whitaker</i>	
24. FUNERAL DIRECTOR ADDRESS <i>De Witz Naval Academy, Annapolis, Md</i>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 A 011

1689

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist

No. 197

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Howard	MARYLAND	STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Florence	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Daniels	03X-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) 6908 Dogwood Road	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last) JOSEPH LEE LE RENDU		2-4-55	19
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH: 11-20-54
9. AGE last birthday: 2 yrs. 4 Months 15 Days		10. IF UNDER 1 YEAR IF UNDER 24 HRS. 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Maryland
13. FATHER'S NAME: Leslie R. Le Rendu		14. MOTHER'S MAIDEN NAME: Katie Compton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY No.: None	17. INFORMANT & ADDRESS: Leslie Le Rendu, Daniels, Md
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
391.2 Immediate cause (a) Purulent Otitis Media Antecedent cause(s) (b) With Septicemia Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: 2		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .			
SIGNATURE George E. Ellicott Ellicott City, Md		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-4-55 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): Buried	DATE THEREOF 2-7-55	NAME OF CEMETERY OR CREMATORY Lisbon Baptist	LOCATION (City, town, or county) (State) Lisbon, Md
DATE REC'D BY LOCAL REG. 2-7-55	REGISTRAR'S SIGNATURE P. B. E. E. Pearl	24. FUNERAL DIRECTOR H. C. Hightower	ADDRESS Ellicott City, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the s of death clearly and legibly.

VS. A15A-5-53



01671

1690
MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 195

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Howard</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Jessups</u> <u>rural</u>				TOWN <u>Jessups</u> <u>rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>One Spot</u>		STREET ADDRESS (If rural, give location)		<u>One Spot</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
CHARLES MC KINLEY NELSON				2-25-55 19			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
Male		Colored		Single		10-18-1954	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
None		None		Howard County, Md			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Russell Purnell Nelson				Shirley Mitchell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:			
No		None		Shirley Mitchell Nelson, Jessups, Md			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
<p><u>714.0</u> Immediate cause (a) <u>Second and Third Degree Burns of</u> DUE TO <u>upper 1/2 of body</u></p> <p>Antecedent cause(s) (b) <u>-</u> Diseases or conditions, if any, giving rise to the above cause DUE TO <u>-</u> stating underlying cause last (c) <u>-</u></p>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
<u>none</u>		
19a. DATE OF OPERATION:		20. AUTOPSY:
<u>none</u>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDING OF OPERATION:		
<u>none</u>		

21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)	
		<u>Home</u>		<u>Jessups Howard Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<u>2 25 1955 10 A.M.</u>				<u>House caught fire with children in it.</u>	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

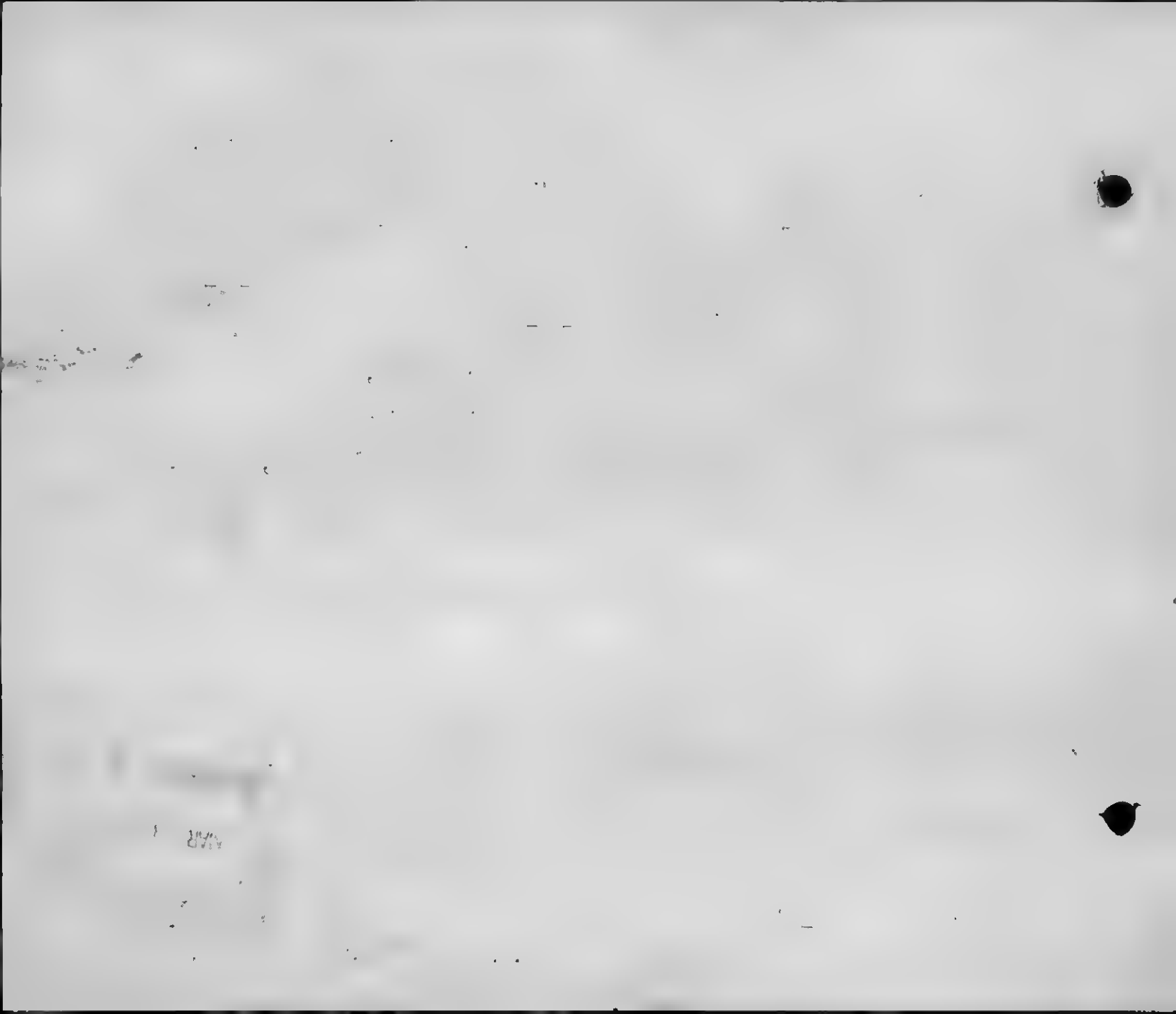
SIGNATURE Eugene E. Bunting CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 2/28/55
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-28-55</u>		<u>One Spot</u>		<u>Jessups Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb. 28, 1955</u>		<u>Frank Shipley</u>		<u>F.C. Higginbotham, Ellicott City, Md</u>			

100-418-40-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1691

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01672

Reg. Dist. No. 191

1. PLACE OF DEATH COUNTY Howard CITY (If outside corporate limits, write RURAL and give nearest town) Ellicott City OR TOWN Ellicott City		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Howard CITY (If outside corporate limits, write RURAL and give nearest town) Ellicott City OR TOWN Ellicott City	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Columbia Road		STREET ADDRESS (If rural, give location) Columbia Road	
3. NAME OF DECEASED (Type or Print) TALTON JOHN PURKEY		4. DATE OF DEATH 2-14-55	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 5-13-1913
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Feed Mill	9. AGE last birthday 41 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Tenn		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Flaner Purkey		14. MOTHER'S MAIDEN NAME Ellen Purkey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY No. 217-18-1738	
17. INFORMANT AND ADDRESS Lilly Purkey, Ellicott City, Md			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4 Immediate cause (a).....

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b).....

(c).....

Acute cardiac failure
Coronary artery occlusion

INTERVAL BETWEEN ONSET AND DEATH

15 mins

15 mins

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Jan 14, 1955**, to **Feb 14, 1955**, that I last saw the deceased alive on **Feb 14, 1955**, and that death occurred at **4:30 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) BURIAL	DATE THEREOF 2/16/1955	NAME OF CEMETERY OR CREMATORY Libanon Good Shepherd	LOCATION (City, town, or county) Ellicott City (State) Md
DATE REC'D BY LOCAL REG. Feb 14, 1955	REGISTRAR'S SIGNATURE John B. Loughman	24. FUNERAL DIRECTOR F.C. HIGGINS & SONS	ADDRESS Ellicott City, Md



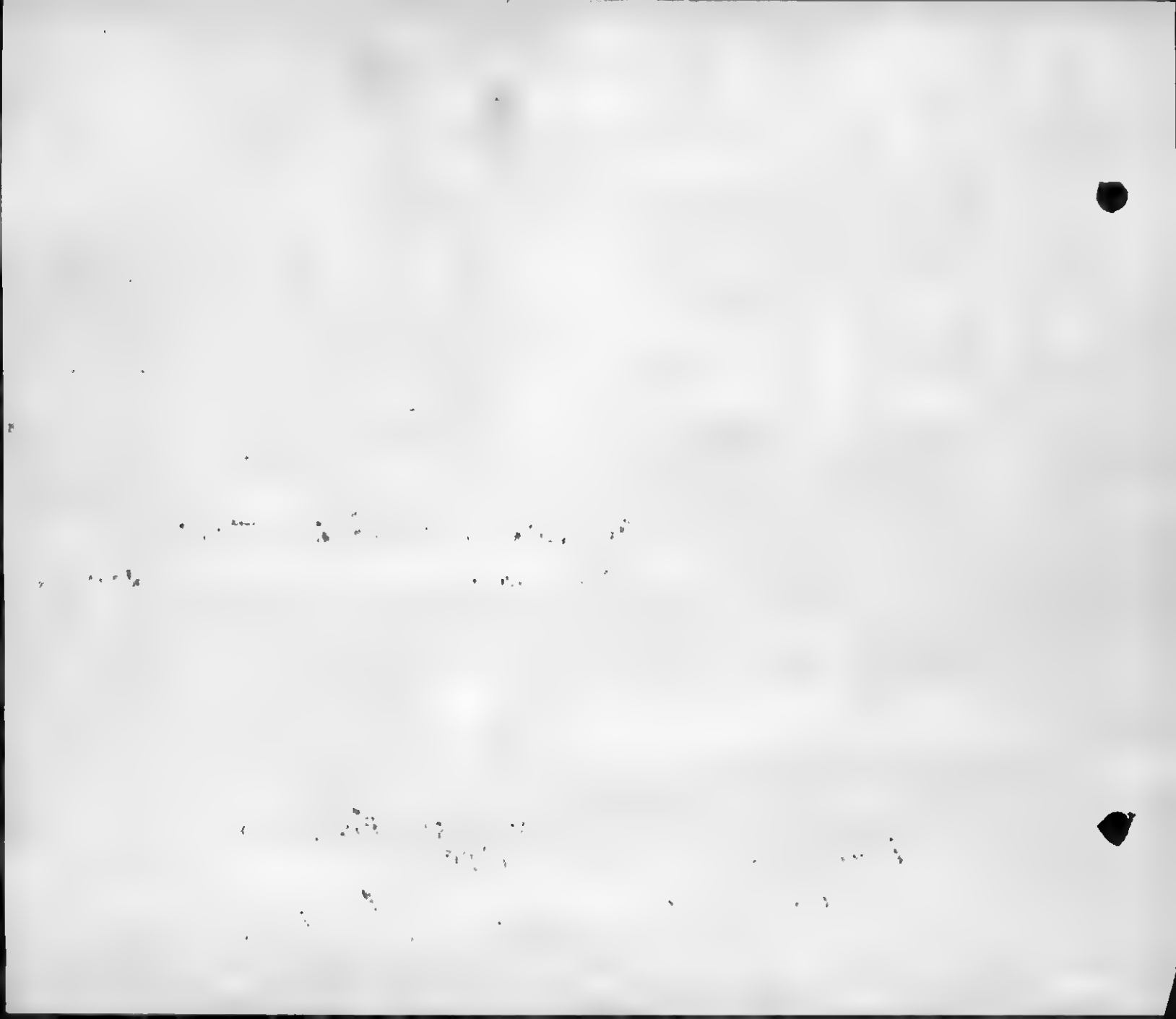
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01673
1692 CERTIFICATE OF DEATH

Reg. Dist. No. 19

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Ellicott City</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highland Manor Nursing Home</u>		STREET ADDRESS (If rural give location) <u>Calvert Street</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH	
(First) <u>JOSEPH</u> (Middle) <u>W.</u> (Last) <u>RENEHAN</u>		<u>February 3, 1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>July 28, 1896</u>
9. AGE last birthday <u>58</u> yrs		10. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>---</u>		14. MOTHER'S MAIDEN NAME: <u>---</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT & ADDRESS: <u>Joan Renehan, 2725 St. Paul Street</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Chronic Nephritis with</u>			
ANTECEDENT CAUSE (S) <u>Edema</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			<u>2-3 yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar</u> , 1954 to <u>Feb 3</u> , 1955 that I last saw the deceased alive on <u>Feb 1</u> , 1955, and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Robert B. Taylor</u>		ADDRESS <u>Ellicott City Md</u>	
DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/5/55</u>	
NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>February 5, 1955</u>		REGISTRAR'S SIGNATURE <u>RW</u>	
24. FUNERAL DIRECTOR <u>Wm. Cooke, Inc.</u>		ADDRESS <u>1217 St. Paul Street</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 190

1693

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harward</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harward</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Jeannette</u>		LENGTH OF STAY (in this place) <u>25 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Jeannette</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) <u>Henry</u> (Middle) <u>Sanders</u> (Last) <u>Sanders</u>				4. DATE OF DEATH: <u>FEB.</u> (Month) <u>7</u> (Day) <u>19</u> (Year) <u>55</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>		8. DATE OF BIRTH: <u>Sept 19, 1878</u>	
9. AGE last birthday: <u>76</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>restaurant</u>		11. BIRTHPLACE (State or foreign country): <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>restaurant owner</u>				13. FATHER'S NAME: <u>unborn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY No.: <u>unborn</u>		17. INFORMANT & ADDRESS: <u>C.W. Jess, Mission Rd, Jeannette, Md</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
Immediate cause (a) <u>MYOCARDIAL INFARCTION</u>				<u>2 WKS</u>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS</u>							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?				Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5 FEB</u> , 19 <u>55</u> , to <u>7 Feb</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6 Feb</u> , 19 <u>55</u> , and that death occurred at <u>1:25 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>George E. Gulean</u> (Degree or title) <u>MD</u>				ADDRESS <u>Chbridge, Md</u> DATE SIGNED <u>7 Feb 55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb 10, 1955</u>		<u>Parkwood Cemetery</u>		<u>Baltimore, Maryland</u>	
REGISTERED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb 8 - 55</u>		<u>E. Bird Williams</u>		<u>De Witt Donaldson</u>		<u>Lanesh, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 11 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1694

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01675

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ELLICOTT CITY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALT. COCC</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shaffer's Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>1236. Ostend ST.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>LOUIS</u> <u>SCHOENE, Sr</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 16, 1955</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>11-22-75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	9. AGE last birthday <u>79</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Un Known</u>		14. MOTHER'S MAIDEN NAME <u>Un Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT AND ADDRESS <u>LOUIS SCHOENE, Sr ELLICOTT CITY, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <u>443X Immediate cause</u> <u>Cerebral embolism</u>		<u>6 days</u>
(b) <u>Antecedent cause(s)</u> <u>Arteriosclerosis of disease with hypertension</u>		<u>5 yrs</u>
(c) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 15, 1955, to Feb. 16, 1955, that I last saw the deceased alive on Feb. 15, 1955, and that death occurred at 3:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>2-19-55</u>	NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>	LOCATION (City, town, or county) (State) <u>Anne Arundel County, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>George L. Schwab</u>	24. FUNERAL DIRECTOR <u>2101 Frederick Ex</u>	ADDRESS



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01676

1695

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH- COUNTY Howard		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Howard	
CITY (If outside corporate limits, write RURAL and give nearest town) Ellicott City		CITY (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) Sylvan Lane	
3. NAME OF DECEASED (Type or Print) Edward		4. DATE OF DEATH (Month) 2 (Day) 22 (Year) 1955	
5. SEX M	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 7/24/1865
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY building	9. AGE last birthday 89 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Carroll County		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Wesley Shipley		14. MOTHER'S MAIDEN NAME Elisa Ann Shipley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY No. none	
17. INFORMANT AND ADDRESS Hilda Shipley, Ellicott City, Md.		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) GANGRENE, LEFT LEG		2 months	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ARTERIO SCLEROSIS		years	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. CONGESTIVE HEART FAILURE			
19a. DATE OF OPERATION NONE		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify) NONE		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. , 19 54 , to FEB. , 19 55 , that I last saw the deceased alive on FEB. 22, 1954 , and that death occurred at 12:15 P. m., from the causes and on the date stated above.			
SIGNATURE Donald E. Fisher M.D.		DATE SIGNED FEB. 23, 1955	
23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE THEREOF 2/25/55	
NAME OF CEMETERY OR CREMATORY St. Johns		LOCATION (City, town, or county) Ellicott City, Md.	
DATE REC'D BY LOCAL REG. FEB. 23, 1955		24. FUNERAL DIRECTOR F.C. Higinbotham ADDRESS Ellicott City, Md.	

B. E. L.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



6/2/71

55.1

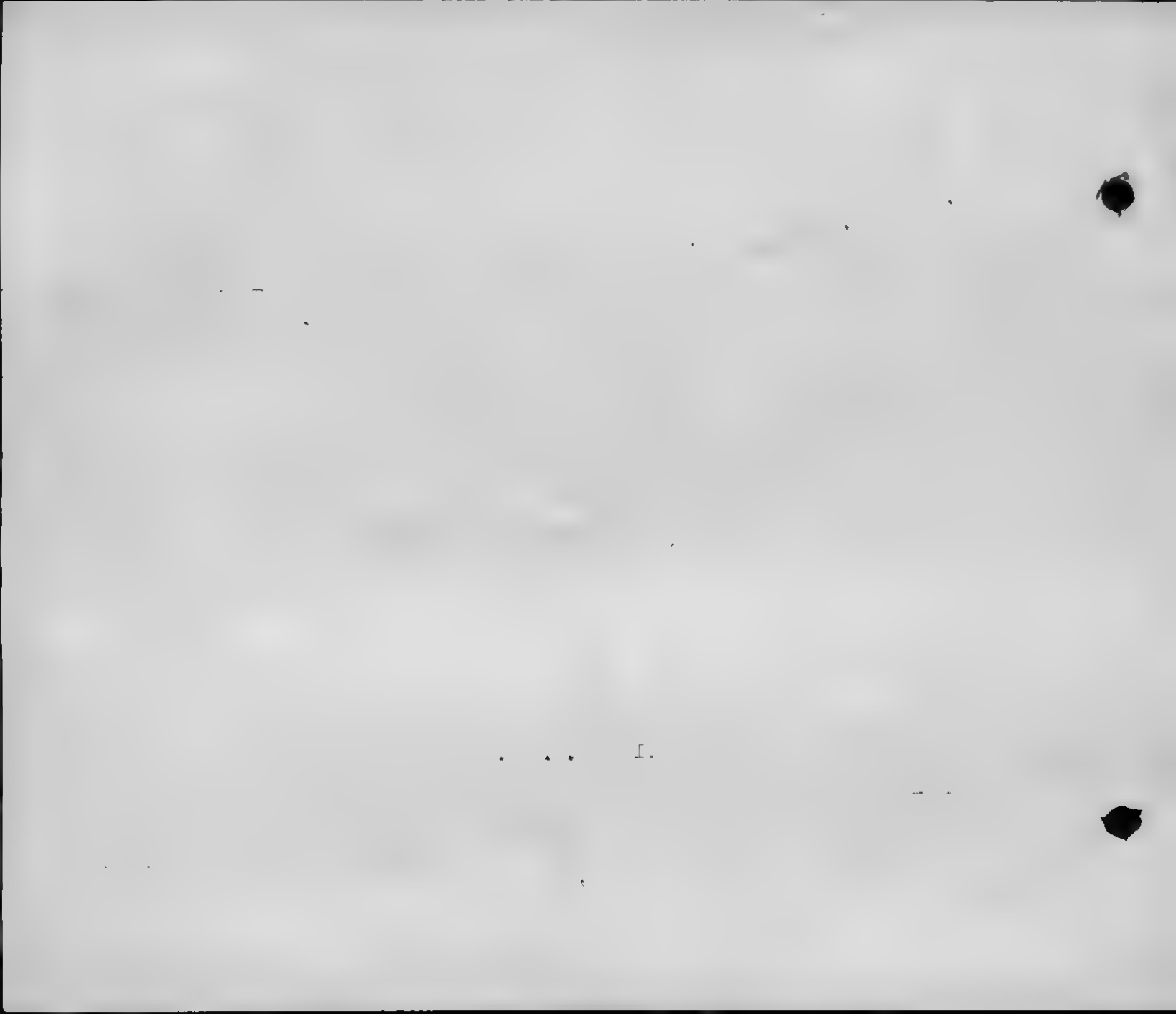
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1697ms 13, 14, Film 178 3-4-55 et
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 01677

Reg. Dist.

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Howard		STATE	Md COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	TOWN N. Laurel		CITY (If outside corporate limits write RURAL and give nearest town)	TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Rt. 1; 20 feet north of Whiskey Bottom Road		STREET ADDRESS	3733 Clarinith Road	
3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	ROSALIE	SILVERMAN		2-28-1955	19
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
Female	White	Single		24 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, (Specify if retired):	10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?	
Collage Student			Baltimore Md		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Abe Silverman			Lillian Hettleman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:	
			218-26-1983	Lillian Silverman - Same	

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Compound, Comminuted Fracture of Skull DUE TO Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO (c)			Instant
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Rt. 1 U.S.	21c. (City or town), (County)	(State)
		N. Laurel	Md
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 2-28-55 9AM	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Head on collision with tractor trailer	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		DATE SIGNED	
George E. Ruston		2-28-1955	
Baltimore City, Md		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	3-1-55	Rosedale	Balto Md
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
March 1, 1955	W. W. Hearn	Jack Lewis One 3100 Cutaw Rd	



1697

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oella</u>		<u>03X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Schaffer's Home</u>				STREET ADDRESS (If rural give location) <u>Pleasant Hill</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>ADA GERTRUDE SIMS</u>				<u>Feb. 22, 1955</u>			
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH: <u>May 5, 1877</u>	9. AGE last birthday: <u>77</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life) <u>Woolen Mill</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Woolen Mill</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George W. Jones</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Proctor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Arthur Sims - Pleasant Hill</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Vascular Disease</u>						<u>4 years</u>	
ANTECEDENT CAUSE (B) <u>Diabetes Mellitus</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>2.0X</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION: <u>None</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/29, 1952</u> to <u>2/22, 1955</u> that I last saw the deceased alive on <u>2/21, 1955</u> , and that death occurred at <u>5³⁰ A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>George E. Buxton</u>		M.D. <u>Ellicott City, Md.</u>		DATE SIGNED <u>2/23/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>2-25-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Good Shepherd</u>		LOCATION (City, town, or county) (State): <u>Ellicott City, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>Feb 23, 1955</u>		REGISTRAR'S SIGNATURE: <u>John B. Loughman</u>		FUNERAL DIRECTOR: <u>Easton Sons</u>		ADDRESS: <u>Catonville Md.</u>	

MARGIN RESERVED FOR BINDING

FORNARD V. S.

1955

1955

MARYLAND

1698

STATE DEPARTMENT OF HEALTH

01679

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Highbridge Laurel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Highbridge Laurel</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Edward</u> (First) <u>Sullivan</u> (Middle) (Last)		4. DATE OF DEATH (Month) <u>February</u> (Day) <u>8</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 21 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State road commission</u>	9. AGE last birthday <u>83</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Pleasant Valley, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Sullivan</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Townsend</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Levin Sullivan Laurel, Md</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a).... <u>Malnutrition</u>			<u>10 wks</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)....			
<u>Carcinoma Tongue</u>			<u>1 year</u>
<u>Metastases to Cervical Nodes</u>			<u>6 mos.</u>
<u>Hypertension, Arteriosclerosis</u>			<u>10 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>12/27, 1946</u> to <u>2/8, 1955</u> , that I last saw the deceased alive on <u>2/7/55</u> , and that death occurred at <u>6:00 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>J. M. Warren M.D.</u>		ADDRESS <u>Laurel</u> DATE SIGNED <u>2/8/55</u>	
23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/11/55</u>	<u>Emmanuel Cemetery</u>	<u>Seagoville, Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Feb 10 - 55</u>	<u>Frank Shipley</u>	<u>Dr. W. H. Randall</u>	<u>Laurel, Md</u>

MARGIN RESERVED FOR BINDING

2000000000

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1699

02754

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. 1 - Old Frederick Road</u>		STREET ADDRESS (If rural, give location) <u>Rt. 1. Old Frederick Road</u>	
3. NAME OF DECEASED (First) <u>Rudolph</u>	(Middle) <u>Tragard</u>	4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 17, 1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Commercial Artist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial Art</u>	9. AGE last birthday <u>89</u> yrs. If under 1 year If under 24 hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Rudolph Tragard</u>		14. MOTHER'S MAIDEN NAME <u>Emma Brandt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Ridgely Poe, Woodbine, Md</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>			
Antecedent cause(s) (b) <u>Arteriosclerosis, Generalized</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb 4, 1955, to Feb 5, 1955, that I last saw the deceased alive on Feb 4, 1955, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W.B. Culwell, M.D. ADDRESS Mt. Airy DATE SIGNED Feb 5, 1955

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF Cemetery OR CREMATORY	LOCATION (City, town, or county) (State)
<u>CREMATION</u>	<u>2-8-1955</u>	<u>Loudon Park</u>	<u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>2/21/55</u>	<u>E. Pearl Manager</u>	<u>C. M. Waltz</u>	<u>Winfield, Maryland</u>

UNITED STATES

1955

1700 Item 12, Film 177 2-15-55 et
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

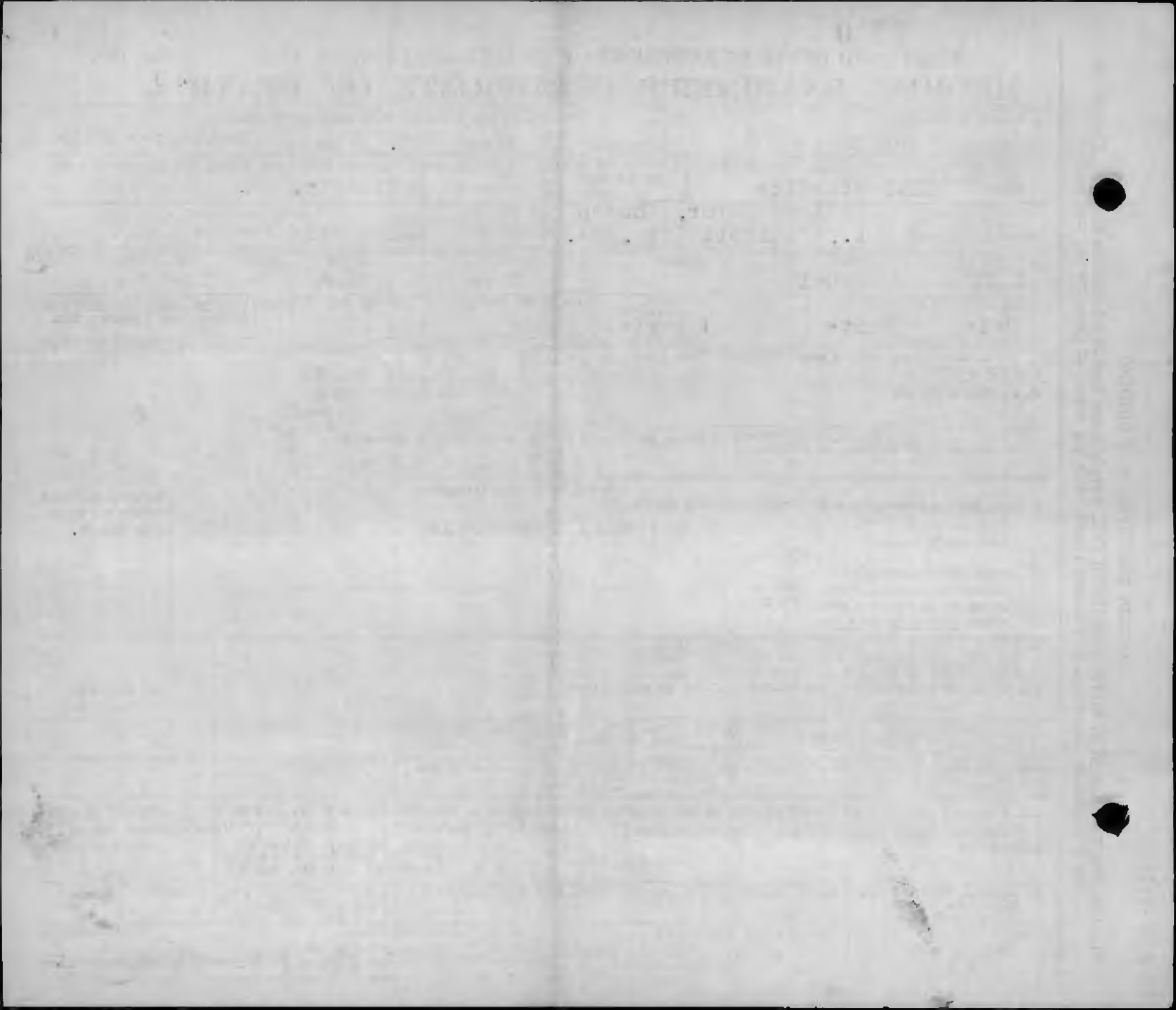
01680
 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR		TOWN	
TOWN <u>Ellicott City</u>		<u>2 days</u>		TOWN <u>Baltimore, Md.</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highland Manor, Church St., Ellicott City, Md.</u>				STREET ADDRESS (If rural, give location) <u>2316 Ocala Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Samuel</u> <u>Warm</u>				<u>2</u> <u>9</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	10. IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>Male</u>	<u>White</u>	<u>Married</u>		<u>48</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Mr. Meyer</u>		<u>Cleaning</u>		<u>Austria</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>David</u>				<u>Bessie Mintzer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
						<u>Kirsch & Son - New York</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>420.1</u> Immediate cause (a) <u>Coronary Thrombosis</u>				<u>5 min.</u>	
DUE TO					
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>George S. Buehler</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>2/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>2-10-55</u>		LOCATION (City, town, or county) (State) <u>New York</u> <u>N.Y.</u>	
DATE REC'D BY LOCAL REG. <u>10-55</u>		REGISTRAR'S SIGNATURE <u>H.W. Hedrick</u>		FUNERAL DIRECTOR <u>Jack Lewis Inc</u> ADDRESS <u>2100 Outlaw Pl</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01681

Reg. Dist. No. 191

1701

1. PLACE OF DEATH- COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Howard	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Ellicott City		LENGTH OF STAY (in this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Annapolis Road				STREET ADDRESS (If rural give location) Old Annapolis Road		1	
3. NAME OF DECEASED (First) DORSEY		(Middle) M.		(Last) WILLIAMS		4. DATE OF DEATH (Month) (Day) (Year) February 18, 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Unknown	9. AGE last birthday 84 yrs.	If under 1 year Months Days Hours	If under 24 hrs. Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Williams				14. MOTHER'S MAIDEN NAME Emily B. Rogers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. None		17. INFORMANT John L. Clark, Atty., Ellicott City			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) Coronary Thrombosis			Immediate
Antecedent cause(s)			
260x Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Cardio-Vascular Disease			5 years
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus			8 years
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 4, 1950, to Feb. 18, 1955, that I last saw the deceased alive on Jan. 28, 1955, and that death occurred at 5 P.M., from the causes and on the date stated above.

SIGNATURE William F. Hassaway		(Degree or title) M.D.		ADDRESS Ellicott City, Md.		DATE SIGNED 2/18/55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Feb. 21, 1955	NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		LOCATION (City, town, or county) Baltimore, Md.		(State)	
DATE REC'D BY LOCAL REG. Feb. 19, 1955	REGISTRAR'S SIGNATURE John B. Loughran	24. FUNERAL DIRECTOR Easton Sons, Catonsville 28, Md.		ADDRESS			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1995

BUREAU V. S.